AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS AND INFORMATION FOR MINOR CHILD(REN)

I, _____, the ☐ Mother ☐ Father
(Print full name of person GIVING release)

☐ other_____ of the following minor child(ren):

Name	DOB

hereby authorize _____ who is the ☐ Mother ☐ Father
(Name of person who is GETTING permission)

☐ other _____ of my minor child(ren) to have access to any and all information regarding the ☐ medical ☐ psychiatric ☐ counseling ☐ other _____ records and information for the minor child(ren) listed above. I also authorize this person to speak to any personnel who may have information regarding such records, and to receive copies of these records and related documents.

This authorization expires ☐ 1 month ☐ 3 months ☐ other _____ from the date of signing below. Copies of this authorization shall be regarded as effective as the original.

_____
(Signature of person GIVING release)

SUBSCRIBED AND SWORN to before me this ____ day of _____, 20_____ at _____, Alaska.

_____
Notary Public in and for _____
My Commission expires:_____